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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXVII SEPTEMBER, 1957 No. 7

ENROLLMENT AND PLACEMENT OF HEALTH EDUCATION MAJORS

Committee on Professional Preparation in Health Education
American School Health Association

WARREN H. SOUTHWORTH, D.P.H., *Sub-Committee Chairman*

This is the second report on Enrollment and Placement of Health Education Majors presented by the American School Health Association Committee on Professional Preparation in Health Education. The first report covered the five-year period 1947 to 1952 and included data from thirty-two institutions. It was published in the January, 1954, issue of the Journal of School Health. The helpful information gained through preparation of its first report prompted the Committee to revise its questionnaire and then gather similar types of data for the three-year period 1952 to 1955.

Completed questionnaires were received from the following 35 institutions:

Brooklyn College
Colorado State College of Education
Columbia University, Teacher's College
Florida State University
Indiana University
Mississippi Southern College
Montana State University
Morgan State College
New York University
North Carolina College
North Texas State College
Oregon State College
Panzer College of Physical Education and Hygiene
Pennsylvania State University
San Jose State College
Southern Illinois State University
Springfield College
Stanford University
*State Teacher's College (Jersey City, N. J.)
State Teacher's College (West Chester, Penna.)
State University Teacher's College (Bridgeport, N. Y.)
State University Teacher's College (Cortland, N. Y.)
Syracuse University
University of California (Los Angeles)
University of Cincinnati
University of Connecticut
University of Florida (Gainesville)
University of Illinois
University of Maryland
University of Michigan
University of North Carolina
*University of Oregon
University of Texas
University of Washington

* Data for 1952 to 1953 only.

The information from these institutions did not include data concerning students who were primarily enrolled in schools of public health.

A. Recruitment

Recruitment Methods. According to the respondents, the recruiting methods which they employed include: (1) distribution of brochures on professional opportunities in health education to high school guidance counselors; (2) distribution of brochures on the major programs in health and physical education to high school administrators and interested high school students; (3) distribution of university catalogs and bulletins (including information about the health education major) to high schools; (4) participation of health education staff members as consultants to public school systems; (5) visitation to high schools by health education staff members; (6) participation by health education staff members in university-wide recruitment programs such as the annual "Careers Day" for high school graduating seniors; (7) contact by letter to all alumni, informing them of career opportunities in health education and asking them to assist recruiting students for health education; (8) participation by health education staff members in all-university advisement and counseling programs; (9) orientation of students to health education through a required freshman course in personal and community health; (10) display of information and materials relative to health education careers in college library, counseling center, and placement office; (11) announcement of scholarships and teaching assistantships for graduate students in health education.

Recruitment Problems. Some of the problems encountered in recruitment of students for health education are: (1) keen competition among professional groups (engineers, physicians, dentists, nurses, architects, and teachers, for example) for recruitment of high school graduates into specialized college curricula; (2) lack of opportunities for directly informing high school boys and girls about the wide variety of health careers, including health education; (3) discouragement of prospective health education students through inadequate health instruction during high school and/or early college years; (4) failure of high school teachers to inform potentially interested students about the opportunities for preparation and employment in health education; (5) need for ways of interpreting more fully the health education major to high school administrators and guidance counselors so that they may, in turn, encourage boys and girls with aptitudes in biological and sociological sciences to consider health education as a career; (6) need for better ways of reaching interested college or university students with information about health education before they select their

major fields of study; (7) need for orienting faculty advisors and counselors in colleges and universities about the health education major; (8) scarcity of positions available to graduates with a bachelor's degree in health education.

B. Undergraduate Health Education Majors

Enrollment. Table I shows the number of men and women who were enrolled during 1952 to 1955 in an undergraduate health education major at the institutions which participated in this study. In any one year there appear to be between two hundred and two hundred fifty undergraduate students who are majoring in health education. Specifically, the enrollments for each of the three academic years are: 238 (1952 to 53), 204 (1953 to 54), and 235 (1954 to 55).

TABLE I
Undergraduate Health Education Majors Enrolled, 1952 to 1955

Classification	1952-1953*			1953-1954**			1954-1955**		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
Freshmen	12	21	33	14	8	22	14	12	26
Sophomores	15	42	57	28	24	52	25	22	47
Juniors	26	44	70	44	32	76	43	51	94
Seniors	38	40	78	27	27	54	29	39	68
Totals	91	147	238	113	91	204	111	124	235

*Data from 32 institutions.
**Data from 30 institutions.

Table II shows the number of men and women who were enrolled in an undergraduate dual major in health and physical education at four institutions during 1952 to 1955. The total enrollment in this type of major is far above that for the single health education major. The figures for each of the three academic years are: 879 (1952 to 53), 957 (1953 to 54), and 1111 (1954 to 55).

TABLE II
Undergraduate Health Education Majors Enrolled in a Dual Major in Health and Physical Education, 1952 to 1955*

Classification	1952-1953			1953-1954			1954-1955		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
Freshmen	172	126	298	206	155	361	310	139	449
Sophomores	111	89	200	140	116	256	160	134	294
Juniors	114	81	195	85	76	161	107	97	204
Seniors	119	67	186	106	73	179	90	74	164
Totals	516	363	879	537	420	957	667	444	1111

*Data from 4 institutions.

Majors Granted Bachelor's Degree. Table III shows that 188 undergraduate health education majors were granted a bachelor's degree during the three-year period 1952 to 1955. The numbers as reported are less than one hundred per year.

TABLE III
Health Education Majors Granted the Bachelor's Degree, 1952 to 1955

	1952-1953*	1953-1954**	1954-1955**	Totals, 3-yr. Period, 1952-55
Men	44	27	28	99
Women	38	23	28	89
Totals	82	50	56	188

*Data from 32 institutions.
**Data from 30 institutions.

Table IV shows that among four institutions which offer a dual major in health and physical education, a total of 519 (more than 150 per year) students received the bachelor's degree through this program during the same three-year period.

TABLE IV
Health Education Majors Granted Bachelor's Degree through the Dual Major in Health and Physical Education, 1952 to 1955*

	1952-1953	1953-1954	1954-1955	Period, 1952-55 Totals, 3-yr.
Men	117	100	86	303
Women	71	71	74	216
Totals	188	171	160	519

*Data from 4 institutions.

Placement of Undergraduate Majors. The placement of 412 health educators, holding a bachelor's degree granted during the 1952 to 1955 period is shown in Table V. Of these health educators, 214, or approximately 52 per cent, are reported to have secured school positions. The positions are distributed as follows: junior and senior high schools 203, elementary schools 7, colleges and universities 3, and schools of nursing 1. Only 24, or 6 per cent, of the graduates are reported to have been placed in public health positions. Ninety-nine, or 24 per cent, entered military service. Another 10 per cent enrolled for further study in colleges or universities. A small 8 per cent, including a few for whom the institutions had incomplete placement data, were listed as having miscellaneous placement. It is important to note that this analysis of placement is based upon an accounting of about 60 per cent of the total graduates from both single and dual health education major programs in the institutions which provided data in this study.

C. Graduate Health Education Majors

Sixteen of the thirty-five institutions responding to the questionnaire offer programs in health education which lead to a teach-

ing certificate and/or graduate degrees. Again, some institutions which are known to have graduate health education programs did not submit data for this study. Further, this study does not include students who were primarily enrolled for graduate study in schools of public health.

Enrollment. Table VI shows that 651 graduate health education majors were enrolled during the 1952 to 1955 period, with an average of more than two hundred students each year. Throughout the three-year period approximately 65 per cent of the health education graduate students are reported as working toward the master's degree while about 30 per cent are working toward the doctoral degree.

TABLE V

Placement of 412 Health Education Majors Granted Bachelor's Degree, 1952-1955

Type of Placement	1952-1953	1953-1954	1954-1955	Total
School Positions				
Elementary School Health Education	1	2	0	3
Elementary School (other)	1	2	1	4
Jr. & Sr. High School Health Education	14	10	14	38
Jr. & Sr. High School Health & Physical Education	58	46	48	152
Jr. & Sr. High School Science	5	4	4	13
School of Nursing	1	0	0	1
Jr. College Health Education	0	0	1	1
College/University Health Education	0	1	1	2
Totals	80	65	69	214=52%
Public Health Positions				
Public Health Department	7	1	2	10
Voluntary Health Agency	6	4	1	11
Unclassified	1	2	0	3
Totals	14	7	3	24= 6%
Military Service	47	32	20	99=24%
Further College or University Work				
Graduate Work, School of Public Health	1	0	1	2
Graduate Work, other than School Public Health	7	8	13	28
School of Physical Therapy	4	3	4	11
Totals	12	11	18	41=10%
Miscellaneous Placement				
Nursing	6	0	0	6
Recreation	1	2	3	6
Housewife	2	1	2	5
Others*	3	1	1	5
Unaccounted For	4	3	5	12
Totals	16	7	11	34= 8%

*These 5 positions were distributed as follows: Post Office Clerk—1; Business—2; Salesmanship—1; Sorority Counseling—1.

TABLE VI

Graduate Health Education Majors Enrolled, 1952 to 1955

Degree or Credential	1952-53*			1953-54**			1954-55*			Totals		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
B. S. & Tch. Credential[1]	3	5	8	4	4	8	4	10	14	11	19	30
Master's Degree	81	62	143	67	49	116	85	73	158	233	184	417
Master's Degree & Tech. Credential			0			0	3	4	7	3	4	7
Director's Degree[2]	1	0	1	2	1	3	1	0	1	4	1	5
Doctoral Degree	42	24	66	37	13	50	48	28	76	127	65	192
Totals	127	91	218	110	67	177	141	115	256	378	273	651

*Data from 16 institutions.

**Data from 14 institutions.

Graduate Scholarships and Fellowships. Table VII summarizes data concerning the availability and awarding of graduate scholarships and fellowships in health education. It appears that there were more scholarships and fellowships available than were awarded during each year of the study.

TABLE VII

Graduate Scholarships or Fellowships in Health Education during 1952 to 1955

	1952-53	1953-54	1954-55
Scholarships or Fellowships Available in Institutions Reporting	15 Health Ed. 5-8 Health or Phy. Ed.	20 Health Ed. 5-8 Health or Phy. Ed.	22 Health Ed. 14-17 Health or Phy. Ed.
Scholarships or Fellowships Awarded in Institutions Reporting	14 Health Ed.	20 Health Ed.	21 Health Ed.

The questionnaire did not obtain information about the scholarship or fellowship stipends. Possibly this should be done in any future studies on graduate health education majors.

Majors Granted Graduate Degrees. Table VIII shows the number of graduate health education majors who were granted a teacher's certificate (involving study beyond the bachelor's degree)

1. Such as is required in California and some other states, where students **may** complete the Bachelor's Degree with a major in health education, and then complete requirements for a general secondary credential during the fifth year, but do not necessarily complete a Master's Degree.
2. Such as is granted by Indiana University.

or graduate degree(s) during the three school-year period from 1952 to 1955. As might be expected, approximately 75 per cent of the group are reported as having received the master's degree, while 15 per cent are reported as having received a doctoral degree. An average of 86 students per year were awarded some type of certificate or graduate degree involving work beyond the bachelor's degree.

TABLE VIII

Health Education Majors Granted Graduate Degrees or Other Credential beyond the Bachelor's Degree, 1952 to 1955*

Degree or Credential	1952-53			1953-54			1954-55			Totals		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
B.S. & Tch Credential	1	0	1	2	3	5	1	1	2	4	4	8
Master's Degree	46	30	76	36	18	54	37	27	64	119	75	194
Master's Degree & Tech Credential			0			0			0			0
Director's Degree	3	0	3	5	0	5	8	0	8	16	0	16
Doctoral Degree	15	4	19	6	2	8	12	2	14	33	8	41
Totals	65	34	99	49	23	72	58	30	88	172	87	259

*Does not include those receiving graduate degrees from schools of public health.

Placement of Graduate Majors. Table IX shows the placement of 198 graduate health education majors who were granted a fifth-year teaching certificate or a graduate degree during the three school-year period covered by the study. One hundred and fifty-one of this group, or approximately 76 per cent, secured some type of school position. These positions were distributed as follows: junior and senior high schools 80; colleges or universities 45; elementary schools 6; schools of nursing 5; school nurse supervisors 7; and health coordinators 8.

Eighteen of the graduates, or approximately 9 per cent, secured public health positions as follows: public health departments 8; voluntary health agencies 6; industrial and commercial health education 3; and unclassified 1.

The remainder of the group followed other pursuits: miltary service, 7 per cent; further college or university study, 3 per cent; and miscellaneous placement, 5 per cent.

TABLE IX

Salary Range of Health Educators,
9 to 10 Months' Basis, 1952 to 1955*

Salary Range	1952-1953 Graduates		1953-1954 Graduates		1954-1955 Graduates	
	Bachelor's Degree	Advanced Degree	Bachelor's Degree	Advanced Degree	Bachelor's Degree	Advanced Degree
$2,700-3,700	81	5	83	6	63	2
$3,800-4,800	15	15	4	22	20	16
$4,900-6,000	0	19	0	6	0	14
$6,100-7,500	0	3	0	1	0	2

* Salary ranges in many areas of the country may have changed materially since this table was compiled.

TABLE X

Placement of 198 Health Education Majors Granted Graduate Degrees or Credentials beyond the Bachelor's Degree, 1952 to 1955

Type of Placement	1952-1953	1953-1954	1954-1955	Total
School Nurse Supervisor	1	2	4	7
Health Coordinator	2	3	3	8
Elementary School Health Education	0	1	2	3
Elementary School (other)	0	1	2	3
Jr. & Sr. High School Health Education	15	6	7	28
Jr. & Sr. High School Health & Physical Education	14	12	8	34
Jr. & Sr. High School Science	0	7	9	16
Jr. & Sr. High School Driver Ed. & Coach	0	2	0	2
Junior College Health Education	2	0	0	2
College/University Health Education	17	11	15	43
School of Nursing	1	2	2	5
Totals	52	47	52	151=76%
Public Health Positions				
Public Health Department	4	3	1	8
Voluntary Health Agency	2	1	3	6
Industrial & Commercial Health Education	2	0	1	3
Unclassified	1	0	0	1
Totals	9	4	5	18= 9%
Military Service	10	2	1	13= 7%
Further College or University Work				
Graduate Work, School of Public Health	2	1	0	3
Graduate Work, Other Than Public Health	2	0	1	3
Totals	4	1	1	6= 3%
Miscellaneous Placement				
Nursing	1	0	0	1
Others*	3	0	2	5
Unaccounted For	2	0	2	4
Totals	6	0	4	10= 5%

*These 5 positions were distributed as follows: Ministry of Education, Thailand—1; Dietician—1; Radio Health Education—1; Dental Hygienist—1; YMCA—1.

D. Undergraduate and Graduate Health Education Majors

Placement. Table X shows the placement of 610 undergraduate and graduate health education majors during the three school-year period covered by the study. This composite table includes the 412 students reported as having received the bachelor's degree plus the 198 students reported as having received a fifth-year teaching certificate or graduate degree.

Three hundred and sixty-five, or approximately 60 per cent, of the total group secured some type of school position. These school positions were distributed as follows: junior and senior high schools 282; colleges or universities 48; elementary schools 13; schools of nursing 6; school nurse supervisors 7; health coordinators 8.

Forty-two, or approximately 7 per cent, of the total group secured some type of public health position. These public health jobs were distributed as follows: public health departments 18; voluntary health agencies 17; industrial and commercial health education 3; and unclassified 4.

Salary Range of Health Educators. Tables IX and XII show the salary ranges reported for *some* of the health educators who received bachelor's and/or advanced degrees *during the three school-year period.* A majority of this group are recent graduates with little or no job experience and who are holding their first health education job. Some of the health educators in the higher paying positions are mature, experienced persons who completed either their doctoral or master's degree during the period covered by the study.

TABLE XI

Placement of 610 Undergraduate and Graduate Health Education Majors, 1952 to 1955

Tpye of Placement	1952-1953	1953-1954	1954-1955	Total
School Positions				
School Nurse Supervisor	1	2	4	7
Health Coordinator	2	3	3	8
Elementary School Health Education	1	3	2	6
Elementary School Health (other)	1	3	3	7
Jr. & Sr. High School Health Education	29	16	21	66
Jr. & Sr. High School Health & Physical Education	72	58	56	186
Jr. & Sr. High School Science	5	11	13	29
Jr. & Sr. High School Driver Ed. & Coach	0	2	0	2
Junior College Health Education	2	0	1	3
College/University Health Education	17	12	16	45
School of Nursing	2	2	2	6
Totals	132	112	121	365=60%

Public Health Positions				
Public Health Department	11	4	3	18
Voluntary Health Agency	8	5	4	17
Industrial & Commercial Health Education	2	0	1	3
Unclassified	2	2	0	4
Totals	23	11	8	42= 7%
Military Service	57	34	21	112=18%
Further College or University Work				
School Public Health	3	1	1	5
Graduate School, Other Than Public Health	9	8	14	31
School of Physical Therapy	4	3	4	11
Totals	16	12	19	47= 8%
Miscellaneous Placement				
Nursing	7	0	0	7
Recreation	1	2	3	6
Housewife	2	1	2	5
Others*	6	1	3	10
Totals	16	4	8	28= 4%
Unaccounted For	6	3	7	16= 3%

These 10 positions were distributed as follows: Post Office clerk—1; Business—2; Salesmanship—1; Sorority Counseling—1; Dietician—1; Ministry of Education, Thailand—1; Radio Health Education—1; Dental Hygienist—1; YMCA—1.

TABLE XII

Salary Range of Health Educators, 10 to 12 Months' Basis, 1952 to 1955*

	1952-1953 Graduates		1953-1954 Graduates		1954-1955 Graduates	
Salary Range	Bachelor's Degree	Advanced Degree	Bachelor's Degree	Advanced Degree	Bachelor's Degree	Advanced Degree
$3,000-4,000	4	2	2	2	2	2
$4,100-5,100	3	5	0	7	0	13
$5,200-6,200	0	5	0	2	0	0
$6,300-7,200	0	2	0	0	0	0

* Salary ranges in many areas of the country may have changed materially since this table was compiled. (Editor's note).

E. Summary

Some of the main points abount *undergraduate* health education programs in American colleges and universities are:

1. According to responses on the questionnaire, about 35 colleges and universities in the United States offer an undergraduate health education major.

2. At least 23 institutions have an active and growing undergraduate health education program. On the other hand, some of the professional health education curricula are still largely paper programs. They report that few or no students have been enrolled or graduated during the period covered by this study.

3. Four institutions report an undergraduate dual major in health and physical education, and they also report high enrollments in this type of program.

4. Among the graduates on whom respondents supplied placement data, it appears that there are positions available for inexperienced health educators with a bachelor's degree. Many of the positions which they hold involve responsibilities in health and physical education at the junior and senior high school levels. However, an impressive number of the positions are described as school health education.

5. Some of the undergraduate majors find employment in public health positions. In the Committee's report for 1947 to 1952, 22 per cent of the undergraduate majors are reported to have been placed in public health education positions. For the period 1952 to 1955 the per cent of undergraduate majors going into public health education positions is only 6. Possibly this shift reflects a greater availability of community health educators from among the graduates of school of public health during the latter period.

6. About 10 per cent of those who receive a bachelor's degree in health education are reported to have enrolled for further college or university study. Very few of these students enroll in schools of public health. Possibly the three-year experience requirement for entrance into the graduate program leading to the Master of Public Health Degree, and the lack of apprenticeship opportunities in public health are deterrents in this instance.

7. The majority of graduates from undergraduate health education major programs are holding positions with salary ranges from $2,700 to $4,800 on a nine- or ten-months' basis and from $3,000 to $5,100 on a yearly basis.

Some of the salient points concerning *graduate* health education programs are:

1. Sixteen of the colleges and universities that submitted data in this study offer graduate programs leading to graduate degrees with a major in health education. This number does not include schools of public health.

2. Slightly more scholarships and fellowship are available than are awarded in health education. It is noted that some of the scholarships and fellowships are available in both health education and physical education, and all of these would not be awarded to health education majors in any one year.

3. It appears that the health education majors who receive graduate degrees beyond the bachelor's degree secure employment. A great majority of them (76 per cent) enter school positions, while some (9 per cent) secure public health positions.

F. Questions

This report raises several questions for further study and investigation:

1. To what extent do undergraduate major health education programs adequately prepare students for school health education and public health education positions?

2. Does the undergraduate dual major in physical and health education provide an adequate preparation in both fields?

3. How many more high school youths become better acquainted with health careers opportunities, including health education?

4. What screening processes will help colleges and universities to identify students who will most likely be successful in undergraduate or graduate health education programs and later in the health education field?

5. What relationships and differences exist between the programs for an undergraduate major in health education, a dual major in health and physical education, and a minor in health education. What competencies does each develop? What criteria are used in formulating these programs?

6. How can school administrators and school boards be encouraged to include health education specialists on their staffs and to use these specialists to the full advantage of the school program?

7. Does the undergraduate health education major serve as a feeder system to graduate programs in school health education and community health education (schools of public health)? If this is desirable, how may some of the "bottlenecks" be overcome?

8. What preparation is desirable for the college health educator?

9. In the graduate program of health education, what degree of differentiation is made in terms of competencies for:

   a. The research worker?
   b. The administrator?
   c. The health educator?

10. Are certification standards keeping pace with advances in health education and the whole area of teacher preparation? What criteria are applicable and what changes are desirable?

G. Committee Membership

Dr. Dora A. Hicks, Chairman. Professor and Chairman Professional Health Education, College of Physical Education and Health, University of Florida, Gainesville, Florida.

Dr. Ross L. Allen; Dr. Carl L. Anderson; Dr. Howard S. Hoyman; Dr. Edward B. Johns; Dr. H. F. Kilander; Dr. Elena M. Sliepcevich; Dr. Louise Smith; Dr. Warren H. Southworth; Miss Marjorie Young.

* * * * *

"WHAT TO DO ABOUT PROBLEMS CONFRONTING ELEMENTARY TEACHERS IN DEALING WITH HEALTH INSTRUCTION"

*Excerpts from—Summary—Discussion Group D**

WARD I. MILLER, Ed.D., *Moderator*

Superintendent of Schools, Wilmington, Delaware

1. *The health condition of the teacher.*
   The physical and mental health of the teacher affects her teaching of health education and her security as a teacher.
2. *How far can and should the school go with respect to community attitude?*
   The teacher must approach health education with an understanding of community mores but with a presentation suitable to the age level of the children.
3. *The direct vs. the inferential method of instruction.*
   While the inferential method of instruction is more applicable in the elementary school, there is need for a guide, for in-service education and a responsibility on the part of the administrator to provide the necessary materials for the program.
4. *The teacher's insecurity in answering questions asked by children.*
   It is the responsibility of the teacher to decide where she can get materials which will help answer questions which she

*National Conference for Cooperation in Health Education, January 1956.

feels insecure in answering. These materials should be suitable to the age level of the children.

There should be pre-service and in-service training for teachers in the field of health education.

Administration backing of teachers is essential in relieving insecurity.

Preparation of a guide where none exists is important.

5. *Getting appropriate teaching materials.*

Teachers should be made aware of the host of materials available and should be led to refer to local Health Departments for such material.

6. *Articulation through all grades of the elementary and secondary school.*

Health education should be a continuing thing. Teacher conferences among and between all grade levels is recommended to implement such a program.

7. *Specialization and the relation of the teacher to the specialist.*

Teachers should feel free to use representatives from school or community organizations as resource people.

8. *Knowledge concerning physical and mental conditions of children and lack of ability to get information from some agencies (particularly mental health).*

Concerns regarding the child's disability (physical or mental) should be a cooperative matter among the parents, the school and the agency handling a special case in the best interests of the child involved.

In attempting to secure information on a particular case the teacher should be aware of the inviolability of the professional ethics involved but we feel that recommendation in handling the child in the classroom should be available to the teacher.

9. *Lack of being able to secure expected results leads to teacher frustration.*

Health education to be effective requires a change in the attitude on the part of an individual, to want to do what should be done.

* * * * *

MEETING

The American Dietetic Association will hold its 40th Annual Meeting in Miami, Florida, October 22 through 25, 1957.

Daytime sessions will take place at the Dinner Key Auditorium where the exhibits of food and equipment companies will be on display.

HEALTH IN PAROCHIAL SCHOOLS

The Formation of a Parochial School Health Council

JOSEPH A. PAPSIDERO, Ed.M.

Health Educator, Montgomery County Tuberculosis and Heart Association, Kensington, Maryland

In Montgomery County, with its population of nearly 300,000 people, interest in health is very high. Its citizens are continually striving to keep abreast of shifting concepts and values so that their communities may attain the highest possible level of health.

In the attempt to achieve this goal, various health councils have been formed, viz, County Health Council, PTA Health Council, Lay Public Health Councils and numerous other lay and professional health committees. Of great importance are the groups whose interest is primarily in the area of school health. These groups have made many worthy contributions and have stimulated much action for the health of children and youth. However, this work has primarily benefited the public schools.

Health in parochial schools has always been an area of general concern in Montgomery County. Recently this concern has been directed into specific action. The Montgomery County Parochial School Health Council was organized in the winter of 1956. It had its origins in the concern of people interested in the health of children in the belief that no child should be handicapped because he fails to receive needed health education and care.

The Council was initiated through the efforts of the Office of Education for the Archdiocese of Washington, the Montgomery County Health Deparament, the Montgomery County Tuberculosis and Heart Association and Health Chairman from each of the Catholic parochial schools.

Because children must spend many years of their lives in school, parochial as well as public, there is responsibility to provide a safe healthful environment, adequate health services and meaningful health education experiences. This obligation falls not solely upon the parochial school, but also upon the home and community. For some time, this need has been openly expressed. Not until the formation of the Parochial School Health Council has there been an organized attempt to meet the need.

The Montgomery County Tuberculosis and Heart Association, in an attempt to improve its programs for the parochial schools, sought the constructive opinions and suggestions of parents and

school personnel. As a result of this inquiry, it was found that there was an increasing desire to obtain a comprehensive school health program. Although the majority of parochial schools in the county had very active health committees, there was a definite need to expand school health programs and to improve existing ones.

Recognizing the importance of getting together and looking at the total picture of parochial school health, the Tuberculosis and Heart Association assumed leadership in the formation of a school health council. Upon receiving an expression of great interest on the part of parents, teachers and school administrators, the Association prepared an outline stating the purposes and functions of the Parochial School Health Council. This outline was submitted to the Director of Education for the Archdiocese of Washington and met with immediate approval.

At this point the Tuberculosis and Heart Association had: (1) determined that there was a major need for the development of a coordinated effort to improve the parochial school health program, (2) gained a wide expression of interest, and (3) obtained the approval and cooperation of school administrators. The next step to be considered was membership on the Council.

The Montgomery County Health Department, already providing nursing and clinical services, but eager to find ways of expanding these services, was very willing to participate as a member of the Parochial School Health Council.

The Office of Education for the Archdiocese of Washington, having endorsed the formation of such a group, would also be represented on the Council.

The principals of the eleven Catholic parochial schools were contacted, presented with specific information about the proposed school health council, and were invited to participate as members. It was emphasized that the Council's effectiveness depended upon the participation of all of the schools. In all cases, the schools assigned their Health Chairmen as their representatives.

Although incomplete, the Parochial School Health Council is now comprised of the following members:

Director of Education, Archdiocese of Washington
Assistant Director of Education, Archdiocese of Washington
Dean of Education, Montgomery County Parochial Schools
11 Health Chairmen
Health Officer
Coordinator of School Health Services, Health Department
Supervisor of School Nursing, Health Department
Dental Clinician, Health Department
Executive Secretary, Tuberculosis and Heart Association
Health Educator, Tuberculosis and Heart Association

As a result of its first meeting, the Council concluded that a comprehensive study of the school health programs was required before any constructive action could be started. This expression of need to determine the status of health in the parochial schools prompted the Council into conducting a preliminary study. The results of this study indicated that: (a) because the majority of parochial schools within the county have been newly constructed, the need for a healthful environment had been substantially met, (b) although the health service programs within the parochial school system require expansion, they are the highest that present facilities and finances will allow, and (c) in many of the parochial schools the health education program is inadequate and requires much improvement and development.

In subsequent meetings progress was rapid. Suggestions were made for the development of a specific course of study in health and that consideration be given to the planning of a parochial school health workshop for teachers and principals, in order to provide them with methods of implementing health instruction in the classroom, consideration was also given to the extended use of health and medical records, including more subjective teacher observation techniques, also to increased use of audio-visual aids, and to the possible initiation of special service programs.

The Council convenes once a month. Each of the parochial schools is scheduled for one meeting so that all teachers, principals and nurses are provided with the opportunity to observe, to participate, and to make direct contributions. These "participatory" meetings have enabled the Council to determine interest and greatly enhanced its work and prestige. At its last meeting before the summer break, the Council formed its first sub-committee to plan and develop a school health manual for health chairmen and nurses. This is the first of what is hoped to be a long line of constructive projects.

The Parochial School Health Council is in its formative stage. As yet its purposes and policies are not too well defined. Even so, it has gained great momentum in its attempt to appraise and improve the health programs of parochial schools. It has assumed an active role in helping to secure and maintain the optimal health of children. Through the cooperative efforts of the church, professional, and lay groups represented on the Council, ways are being found to meet the specific health needs of all children in parochial schools.

FIVE YEARS OF PROGRESS WITH THE TEACHER NURSE SERVICE IN THE CHICAGO PUBLIC SCHOOLS

MADELINE ROESSLER, R.N., M.A.

Supervisor of Health Services, Chicago Public Schools

The year 1952 when the first nine teacher nurses and a supervisor started health programs in seventeen Chicago Public Elementary Schools, now seems very remote. Each succeeding year, teacher nurses were added to the Bureau of Health Services despite serious budget problems due to the rapid increase in pupil enrollment. By 1956 there were three supervisors and 58 teacher nurses and in 1957, the budget provided for 72 teacher nurses and the three supervisors.

The statement made in 1953 still holds true — "To foster the teacher nurse program, respect and understanding and leadership must emanate from administration and supervision."[1] From experience the words should be added, "at the local school level as well as the central organization." Likewise, the community civic and professional groups have continued their interest and support of the program.

The requirements for the teacher nurse position are basically the same — current nurse registration and a bachelor's degree. Adjustments in the requirements now call for 15 hours in education. Teacher nurses are urged to undertake graduate work in the field of Public Health Nursing. Salaries are based on academic status which compensates for this additional study. Recruitment of teacher nurses has been facilitated with increased university resources, and teacher nurses are "selling the job" to their colleagues.

The teacher nurse services have been expanded. It is no longer a demonstration in a few selected schools, but an exploration to provide the best quality and quantity of health services to the children in the Chicago Public Schools. The program has been based on the philosophy that school health problems are the mutual concern of home, school and community, and parents have the primary responsibility for maintaining the health of their children. The assignment of a teacher nurse to an individual school faculty is basic to a successful school health program in individual communities.

1. "What Nurses are Doing to Raise the Standards and Status of School Nurses"—by Madeline Roessler, R.N., Ph.B., M.A.—**Journal of School Health**, April, 1954.

Programs such as identification of pupils with major health problems, the follow-up of pupils with heart disease, epilepsy, cleft palate and other serious problems, have been developed on a city-wide basis. Providing teacher nurse services to 413 schools and 428,379 pupils becomes a major task.

Schools to which teacher nurses are assigned, following a formal written request from the school administrator, are carefully selected with the cooperation of local and central administration. In the school year 1956-57, 49 teacher nurses were assigned to 108 schools which included 87 elementary schools and 4 branches, 4 regular high schools, 2 vocational high schools and 2 branches, 4 elementary and 1 high school for the physically handicapped, and 2 social adjustment schools and 2 branches. Located in these schools are special education divisions such as two centers for trainable mentally handicapped, 68 divisions for the educable mentally handicapped, 4 divisions for blind, 10 divisions for partially seeing, 9 divisions for deaf, and 3 social adjustment divisions.

Teacher nurses not regularly assigned to schools serve the remainder of the schools for follow-up of those pupils suspected or known to have major health problems. These teacher nurses are referred to as district teacher nurses, and several patterns of school assignment have been developed. They work out of two district offices located in schools where district superintendents' offices are established. A supervisor is in charge of each district office.

For the teacher nurses assigned to schools, the pupil case load average is 2336, the minimum 234 and maximum 6085, while the district teacher nurses are responsible for five to 30 schools. The plan of organization requires the keenest of professional skills, not only in planning but in executing a good school health service program. Such programs require flexibility in terms of teacher-nurse function because of their dynamic nature. The health programs will continue to develop and the teacher-nurse service will be extended to meet each school and community need.

Evidence of teacher nurse performance has been compiled in the 1956-57 School Year Annual Report of pupil health services.

Conferences for Family Health Service

Home Visits	8,103
Conferences with parents at school	16,664
Conferences with pupils at school	23,220
Number of pupils discussed in conferences with teachers	51,708
Conferences with others	8,499
Telephone Conferences—Incoming and Outgoing	19,974

Screening by Teacher Nurse	
*Vision—Special Referrals	7,962
*Hearing—Special Referrals	8,004
Height and Weight—Special Study on Growth	7,026
Inspections of pupils referred to teacher nurse	30,903
Referrals—Selected	
Private Physicians	7,894
Private Dentists	5,348
Clinics or Hospitals	8,369
Division of Services for Crippled Children	249
Rehabilitation Institute (Cardiac)	87
Psychological Service	411
Referrals—Routine (in compliance with State School Code)	
Medical and dental for entering pupil	15,445
Medical and dental for fifth grade pupil	3,466
Medical and dental for entering high school pupil	5,480

* Routine Screening is done by teachers trained in hearing and vision-screening techniques and assigned to the Hearing and Vision Conservation Program.

The number of pupils with special health problems followed up by teacher nurses, not including those pupils enrolled in special schools for the physically handicapped, shows an increase each year. For 1956-57, pupils were given service by the teacher nurses for the following:

Rheumatic Heart Disease	996
Congenital Heart Disease	217
Acute Rheumatic Fever	188
Epilepsy	477
Cleft Palate	204
Diabetes	72
Asthma	245
Neurological	223
Orthopedic	369
Severe Organic Disturbances	189
Voice Disorders	95
Tuberculosis	124
Other Long-term Illnesses	912

Teacher nurses have always been given the opportunity to be self-directing. They have studied the problems of assignments, procedures and forms. They have participated in special projects. Some of these are the development and revisions of the "Guide for Teacher Nurses;" special studies and follow-up on cleft palate, rheumatic fever, the under-par child; epilepsy; epidemiological studies on tuberculin testing; development of the "Emergency Care Flip Chart;" fluoridation surveys and studies; and the development of programs with cardiac and epilepsy medical consultants.

Planning the organization and extension of the teacher-nurse service is still a challenge to health administration, as aptly stated by the Medical Director of the Bureau of Health Services.

"The effective number of teacher-nurses per pupil is still a great variable as it relates to the many types of communities in the city. The present rate of expansion, if it can be maintained, barely keeps up with the health needs of such a rapidly growing school population as Chicago."

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ESSENTIALS OF NUTRITION

HENRY C. SHERMAN, Ph.D., Sc.D., *and*
CAROLINE SHERMAN LANFORD, Ph.D.

4th Edition, Published March 26, 1957, College Department, The MacMillan Company, 60 Fifth Avenue, New York 11

The authors develop the premise that improvement of life through better nutrition involves not only a study of dietary deficiencies, their prevention and correction, but also a thorough knowledge of minimum requirements and recommended dietary allowances to the end that all people shall be well nourished, and may recognize the accepted fact that there are degrees of good health and that we should strive to attain the highest possible degree for each individual.

In this new fourth edition, the authors have brought up-to-date the newer knowledge on foods, their components, their uses and specific values in the body, and products of their digestion, vitamins, minerals, effects of deficiencies and disproportions, specific tolerance by individuals, weight control, etc., in a style which, while obviously scientific and authoritative, still made good reading for college students and their teachers. An appendix listing protein, fat and carbohydrate content and energy values of foods in grams per cent, together with a glossary of terms make this a very usable text.—*M.A.H.*

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NOTE FROM 1956 ASHA MEETING
ADOLESCENCE

Dr. J. Roswell Gallagher, "The three areas of confusion in adolescence are sex, business of acquiring independence and need for success and recognition. Rest and restriction are contrary to the nature of the adolescent. Activity is a more fitting prescription. This is the age when strength is built through physical exercise. Voluntary inactivity ought to be regarded as unusual. It is by doing more and still more that ones capacity to recover is increased. The adolescent who does not live strenuously may become obese. According to farmers the world over, the first step in producing lard is to reduce the expenditure of energy."

EAT AND BE MERRY*

DOROTHY SPURLING, M.Sc.,

Nutrition Consultant, State Department of Public Health
Berkeley, California

Ethel Austin Martin in this new book, *Roberts' Nutrition Work with Children*, makes the statement, "Nutrition is to total health what reading is to education." Neither health nor education can be attained without the basic requirement.

The subjects for this School Health Conference — Mental Health and Nutrition — seem highly appropriate because they are closely linked in the life of each individual.

Eat and Be Merry implies good nutrition, also mental health. Let us consider some of the psychological aspects of eating and some factors that influence food practices.

The child's early feeding experiences are the foundation of many of his life patterns, as well as his attitudes concerning food and eating. Little children are imitators. They want to do the same things and eat the same kinds of foods as the adults they love and admire. This tendency to imitate family food practices results in cultural patterns which may be handed down from generation. The liberal use by Southerners of green leafy vegetables and "pot-likker" is an example of a well established cultural pattern of eating. The biscuit and gravy combination may not be so commendable. We need to be careful in criticizing cultural food patterns that do not coincide with our own. Some studies have shown that many Mexican diets, though different, were better than those of Americans at a comparable income level.

Children may acquire some poor as well as good family patterns of eating. One of the great deterrents to a desirable attitude toward food and eating is that of forcing little children to eat. Knowing the importance of food to health, parents are concerned: They want to be sure that the child eats enough of what is best for him. As a result of pressure at mealtime, tensions and tantrums may occur in some families. The child may sense the anxiety of his parents and enjoy the excitement. He may capitalize on it for the purpose of perpetuating the drama.

Many a child wants to prove that he is master of the situation whether the problem is related to food or to something else. A psychiatrist, when asked about stubbornness in children, de-

*Presented at the regional meeting of California School Health Association at Red Bluff, California, April 27, 1957.

scribed a cartoon of a man attempting to lead a reluctant mule that had assumed a stance befitting his species. This was the philosophic comment of the mule below the cartoon: "My what a stubborn man!" One can scarcely imagine a situation in which forcing or requiring a child to eat a certain food or foods is justified. Encouragement, yes! But stern discipline at mealtime might quite conceivably result in life-long trauma. There are acceptable, common-sense ways of helping a child to adjust — ways which make eating enjoyable.

Emotions and attitudes may exert powerful influences over the kinds and amounts of food eaten. Either underweight or overweight can occur in a child with disturbed eating habits. It is recognized, of course, that some children are underweight for the simple reason that sufficient food is not available.

Personality and social problems of both underweight and overweight children may be quite tragic. As we know, children are not always kind. They are prone to emphasize abnormal size of classmates by nicknames such as "Pee-wee," "Skinny," "Fatso" or "Fatty" or just plain "Fat." This may damage a child's personality and change the entire pattern of his life.

Some fat children become fatter as they grow older. Being overweight may make them feel inadequate and inferior. To compensate for these depressing emotions, they may munch foods between meals, also become withdrawn, less active and lonely.

Several food intake studies have been made of obese children and of their non-obese contemporaries. Findings reveal that many obese children do not ingest more calories than their contemporaries of the same sex and of similar age and build, but they are less active physically.

For both children and adults, exercise has taken on a new significance in weight control. Instead of unduly stimulating the appetite, as once thought it is known to increase caloric expenditure significally. Exercise may be a more easily manipulated factor in weight control than food consumption.

Some of the problems of weight control have been presented for the reason that obesity is a major public health problem in the United States. The best conservative estimates place the figure at one-fifth of the adult population over 30 — or one of every five adults. Similar data are not available for obese children.

The reason obesity is considered a major public health problem is that death rates from all causes are above normal for over-

weight persons at every age. Death rates increase with the degree of overweight for both men and women.

It is well known that obesity results from consuming more calories than are needed. Obesity may occur from being a member of a family where a laden table is regularly set and where food is emphasized to the extent that the family habitually eats beyond the point of satiety.

Authorities on weight control report that many people become obese as a result of psychological problems for which the individual has found no satisfactory solution. For those struggling with such problems, food acts as a sedative, giving temporary solace and comfort.

Lack of interest in the things of life — boredom in other words — is said to be another cause of excessive eating. This group may derive little, if any, satisfaction from work, friends, art, music or hobbies. Some individuals are described as compulsive eaters, unable to restrict food intake.

"The only answer to obesity is prevention," according to our best authorities on weight control. They have arrived at this conclusion because efforts in maintaining reduced weight have been generally unsuccessful. If during all the early years at school, we can help children establish good food habits and stable attitudes toward food, they will be less susceptible to the problem of obesity. This discussion on weight control may seem a bit depressing, although the title, *Eat and Be Merry*, implies the need for a pleasant, joyous atmosphere at mealtime. Such an atmosphere makes eating as enjoyable as it is necessary.

Some teachers have said that in all their experience in encouraging good food practices, nothing has equalled in effectiveness, the opportunity of actually eating lunch with the children. Socializing at mealtime and a real acquaintance with the children that results from this experience are said to be a two-way learning experience. In this mealtime setting the teacher gradually learns about the individual child's social capabilities and much about what makes him "tick," and also about his attitudes toward food and eating.

The school lunch programs have been of tremendous value in increasing the variety of foods liked by children and in improving their nutritional status. The number of school lunch programs has increased in recent years and the quality of food served has improved.

Our jobs — yours and mine — are not finished! In recent studies of food practices of school children in north-central California, only nine percent reported foods that would supply a major portion of recommended dietary allowances of essential nutrients for children in elementary grades. In these studies, some children reported including no fruits, some no vegetables and some no milk.

Evidence has been accumulating throughout the world which shows that growth, ultimate size, structure of bones and teeth, physical vigor and length of life, are all dependent in large measure on nutrition at various stages throughout the life span.

Dr. Charles Glen King, eminent in the field of nutrition, states it this way: "Few discoveries in science have been more striking than those that demonstrate the importance of nutrition — early in life — as a means of protecting health in later years." We can't afford not to teach nutrition as well as we can. We all have responsibility since it is becoming increasingly evident that the same food that builds strong and healthy bodies and maintains normal weight, plays an important part in mental health and in emotional behavior.

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NATIONAL INSTITUTE OF MENTAL HEALTH RECOMMENDATIONS

Recommendations for applying current knowledge towards the solution of 5 major mental health problems as proposed by the National Institute of Mental Health are presented in a bulletin issued by the Social Legislation Information Service. The problem areas covered are:

JUVENILE DELINQUENCY
MENTAL RETARDATION
AGING
ALCOHOLISM
ACCIDENT PREVENTION

The recommendations are part of a statement submitted to Congress by Dr. Robert H. Felix, Director of the National Institute of Mental Health, in the course of justifying a multi-million-dollar budget request for the new fiscal year.

The bulletin, "5 MENTAL HEALTH PROBLEMS," is available for 25c a copy from the Social Legislation Information Service, 1346 Connecticut Avenue, N.W., Washington 6, D. C.

WHAT IS THE SCOPE OF SCHOOL HEALTH AND HOW DOES YOUR SCHOOL RATE?

(From the Colorado Education Association's JOURNAL—October, 1956)

The list below includes the major responsibilities which schools have for the health and safety of children.

The five items below should be integrated within the school and community.

This check list is devised for use by administrators, teachers, students, councils or others wishing to appraise the scope and adequacy of their school health program. There are printed materials from the Colorado State Department of Education and State Department of Public Health on the topics starred (*) below.

1. *Sanitary, safe and wholesome environment*

	Yes	No
*a. Are the state approved medical certificates required for all personnel?		
*b. Is there a written plan for first aid care of illness and accidents?		
*c. Do the buildings and grounds meet state or local sanitary standards?		
*d. Are cases of communicable disease detected and excluded promptly according to state policy?		
*e. Are the state policies for busses being followed?		
*f. Are the state policies for lunchrooms being followed?		

2. *Graded health and safety education*

	Yes	No
a. Is there a written plan of health instruction throughout all the grades?		
b. Is physical education a regular part of the program for all pupils?		
c. Are pupils prepared to understand the health services offered in the school and community?		
d. Are first aid courses offered in the high school?		

3. *Detection of health problems that may diminish effectiveness of the educational program*

	Yes	No
a. Is vision on all pupils periodically checked?		
b. Is hearing on all pupils regularly checked?		
*c. Are you using the new state bulletin on testing vision and hearing?		
d. Is attention paid to periodic growth measurements?		
e. Are children screened regularly for dental health?		
f. Are medical evaluations of all pupils made periodically?		
*g. Are cumulative health records maintained on all pupils?		

4. *Guidance on these health problems of individual pupils, including counsel with parents and others*

	Yes	No
a. Is professional follow-up given to known health problems?		
b. Are the community health facilities known and used?		
c. Are these community facilities adequate for pupil needs?		

5. *Special facilities for physically, mentally and emotionally exceptional children who are educable*

	Yes	No
a. Are these pupils accurately classified for their learning potential?		
b. Are special programs available for all exceptional children?		

Has your school developed other health projects? If so, would you kindly write Mrs. Marguerite Juchem, Chairman of the Colorado State Advisory Committee on School Health.

Referred to the Journal of School Health by A. O. DeWeese, M.D. Further information may be obtained from Mildred Doster, M.D., Denver Public Schools, 414 Fourteenth St., Denver 2. Colo.

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ERRATUM

Your attention is directed to an error in the article titled "Acne, Complexion Problem of Young Adults" submitted by Herbert Lawrence, M.D., and published in June, 1957, (Vol XXVII, No. 6). On page 168, answer No. 3, should have read "astringents which are recommended by most dermatologists should not be prescribed by non-medical personnel."

We regret this error and thank Dr. Lawrence for calling it to our attention.

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PERSONAL

The Bulletin of The Medical Society of the County of Erie, New York, for June, 1957, carried a notice of the death on June 1, 1957, of Arthur C. Schaeffer, M.D., at the age of seventy-four years.

Dr. Schaeffer was the courteous gentleman who, as the Deputy Health Commissioner of the City of Buffalo, welcomed heartily the group of sixty persons — fifty-six of them physicians — interested in School Health who had met at the Convention of the American Public Health Association on Wednesday, October 13, 1926, at dinner to discuss "school medical inspection problems."

This meeting resulted in the organization of what is now the American School Health Association with a present circulation of its Journal of School Health of six thousand.

The Historical Committee of the American School Health Association.—*C. H. Keene.*